

ST. LOUIS GYNECOLOGY & ONCOLOGY, LLC

AL ELBENDARY, MD, FACOG, FACS

Board Certified in Gynecologic Oncology & Gynecology

Patient Information Sheet

Please Print and fill out form **completely**. Incomplete forms may result in extra out of pocket expense for patient.

Patient

Name: _____

Date of Birth/Age: _____

Patient Address: _____

Social Security #: _____

City: _____ State: _____ Zip: _____

Marital Status: _____

Phone #: (Area Code) _____

Employer: _____

Cell Phone #: (Area Code) _____

Employer Phone: _____

Insurance Information

PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS. THEY CONTAIN POLICY, GROUP AND TELEPHONE NUMBERS WHICH ARE VERY IMPORTANT FOR PRECERTIFICATION AND ADMISSION REQUIREMENTS.

Primary Insurance Company: _____

Policyholder's Name: _____

Address: _____

Policyholder's Employer: _____

City: _____ State: _____ Zip: _____

Policyholder's Date of Birth: _____

Policy I.D. #: _____

Policyholder's S.S. #: _____

Policy Group #: _____

Secondary Insurance Company: _____

Policyholder's Name: _____

Address: _____

Policyholder's Employer: _____

City: _____ State: _____ Zip: _____

Policyholder's Date of Birth: _____

Policy I.D. #: _____

Policyholder's S.S. #: _____

Policy Group #: _____

Primary Care Physician: _____

Referring Physician: _____

Phone # (Area Code): _____

Phone # (Area Code): _____

Fax # (Area Code): _____

Fax # (Area Code): _____

In case of emergency, please list name and telephone number of nearest relative or friend:

Name: _____ Phone #: (Area Code) _____ Relationship: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. You are responsible for any co-payments, deductible amount and co-insurance or any balance not paid by your insurance carrier.

Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits to be made directly to the physician or supplier for services rendered.

Signed: _____ Date: _____

I authorize Gynecology & Oncology Consultants, PC to use any information acquired in the course of my examination for treatment, payment and health care operations.

Signed: _____ Date: _____